others have used the term prothrombin index. This has been expressed as a percentage of the clotting times of the control and test samples, so that from the first example above $\frac{14}{28} \times 100 = 50\%$. Yet others have used dilution curves prepared from control plasma diluted with saline or with adsorbed plasma. These curves again have provided different results.

This failure of standardization has led to two difficulties. The patient on long-term treatment who moves from one part of the country to another has difficulty in getting it controlled. The second is the inability to compare the results of a trial of anticoagulant therapy in one centre with those in another because the intensity of the anticoagulant effect has been different. A national system for anticoagulant control has therefore been proposed.

The main variable in the prothrombin-time test is the tissue extract thromboplastin.[2-4] The British Committee for Standardization in Haematology has therefore made two proposals:

(1) The Manchester comparative reagent, which is used as a routine over a large area in the North of England and the Midlands, shall now be designated the British Comparative Thromboplastin (B.C.T.), and shall be generally available as the reference preparation. In addition to the strict quality control at the production centre at Withington Hospital monitoring of batches will be carried out at a number of officially recognized hospitals to see that they conform to accepted criteria.

(2) A uniform system of reporting is also recommended based on a prothrombin ratio—that is, patient's prothrombin time divided by normal prothrombin time. With every prothrombin result, whether it is reported as prothrombin activity, ratio, or index at an individual hospital, a prothrombin ratio termed the British Corrected Ratio (B.C.R.) should be given. This is a prothrombin value corrected for the difference between the local hospital's reagent and the B.C.T.

It is hoped that these measures will create uniformity of laboratory testing and allow clinical trials to be related to the "intensity of treatment" used at any hospital. Furthermore, when a patient moves from one area to another the levels of anticoagulation may be comparable.

Representation of Hospital Junior Staff

Whatever the merits of the hospital junior doctors' case for better representation within the B.M.A., the Hospital Junior Staffs Group Council was wrong to act as it did last week. As reported in the *Supplement* (page 17), the Group Council adjourned *sine die*, subject to procedure it laid down for its recall, in support of active attempts to obtain from the Central Committee for Hospital Medical Services an assurance of support for a method of hospital junior staff representation within the Association along the lines of a document previously put to the Central Committee by the Group Council. Central to this method was the creation of a standing committee of the B.M.A. to represent the interests of hospital junior staff. A motion to create such a standing committee was rejected by the Representative Body at Aberdeen.[1]

[1] *British Medical Journal Supplement*, 1969, 3, 49.

Leaving aside the question of the Group Council's constitutional competence to suspend itself and to state the terms on which it will allow itself to be resuscitated, its right to disenfranchise its constituents without consulting them can certainly be challenged. Apart from the actual adjournment, the Group Council's self-made rules make the inability of its members to act for the time being for those they represent quite evident. Only the Chairman is left with any functions. Representatives of the Group Council on the Council of the Association or any other committee are instructed to decline to attend meetings of the body concerned and to refrain from speaking to any matter "whether or not reflecting the policy of the Group Council." It is to be hoped that from among the regional group committees of hospital junior staff seven (the number ordained by the Group Council) will be moved to demand the recall of their central committee and thus end an ill-conceived medico-political demonstration. In any event, the B.M.A. cannot ignore for too long the disruption of its organization.

It so happens that while the B.M.A.'s machinery for representing hospital junior doctors is temporarily crippled the Junior Hospital Doctors' Association is promoting "a new hospital doctors' charter." In handouts to a press conference this week to launch the charter the J.H.D.A. clearly stated its antagonism to B.M.A. policy—an antagonism, of course, which it has every right to state. Not so clear, however, is the position of those elected members of the B.M.A.'s Hospital Junior Staffs Group Council who are also prominent in the J.H.D.A. For example, Dr. J. F. G. Pigott, the Group Council's Chairman, is also Chairman of the J.H.D.A. Since the two bodies are so plainly in different camps the question of where loyalties lie is bound to arise, and it is a question that should be answered.

Road Accidents and the Family Doctor

Two important conferences have been held in Britain this year around the theme of road accidents; the first on schemes for emergency care at the roadside,[1] and the second on ambulance design.[2] These showed that many doctors, in this country and abroad, want to become more involved in treating injured persons at the roadside—whether on the lines of the scheme run by Professor Eberhard Gögler at Heidelberg (in which the doctors are based on the hospital casualty department) or of that organized by Dr. K. C. Easton and his colleagues in North Yorkshire (in which general practitioners are called out). To help family doctors who have inquired about schemes of this kind the Medical Commission on Accident Prevention has recently produced a broadsheet, giving guidance on the role of the general practitioner and the equipment recommended for doctors.[3]

This week we start a new series of articles on the treatment of injuries at the roadside. Besides articles on organization and medical equipment these will include contributions on the management of soft tissue injuries, resuscitation, fractures of the spine, and extrication of persons trapped in a vehicle. We hope that these will interest all doctors concerned with what has become one of the major epidemics of our times.

[1] *British Medical Journal*, 1969, 2, 398.
[2] *British Medical Journal*, 1969, 4, 60.
[3] Obtainable from the Commission at 50 Old Brompton Road, London S.W.7.